Marian K. PITTS, Murray COUCH, Hunter MULCARE,
Samantha CROY, Anne MITCHELL

Transgender People in Australia and New Zealand: Health, Well-being and Access to Health Services

This research had its beginnings in an act of trans activism, including a campaign by a number of trans organizations advocating the need for research dealing with health, well-being and access to health services in relation to this population. This study set out to recruit the broadest possible community sample by using a range of recruitment techniques and an online survey. In total, 253 respondents completed the survey. Of these, 229 were from Australia (90.5%) and 24 (9.5%) were from New Zealand. Respondents rated their health on a five-point scale; the majority of the sample rated their health as 'good' or 'very good'. On the SF36 scale, respondents had poorer health ratings than the general population in Australia and New Zealand. Respondents reported rates of depression much higher than those found in the general Australian population, with assigned males being twice as likely to experience depression as assigned females. Respondents who had experienced greater discrimination were more likely to report being currently depressed. Respondents were asked about their best and worst experiences with a health practitioner or health service in relation to being trans. They contrasted encounters where they felt accepted and supported by their practitioners with others where they were met with hostility.

Key Words: *depression, health service use, self-reported health, recognition, trans*

INTRODUCTION

This research had its beginnings in an act of trans[1] activism. In 2005, the Australian Research Centre in Sex, Health and Society (ARCSHS) was collecting data, online, from the gay, lesbian, bisexual, trans and intersex (GLBTI) communities for the Private Lives project (Pitts et al., 2006). Members from various trans communities in Australia, in an organized campaign, contacted ARCSHS. A conversation began about the need for an additional survey to address the

Feminism & Psychology © 2009 SAGE (Los Angeles, London, New Delhi, Singapore and Washington DC) http://fap.sagepub.com, Vol. 19(4): 475–495; 0959-3535
DOI: 10.1177/0959353509342771

Downloaded from fap.sagepub.com by guest on April 11, 2016

particular shape of trans lives and some of the specific shared issues, including access and the quality of heath services. Out of these conversational beginnings, the TranZnation Survey that is reported here was developed and implemented.

Studies investigating health and well-being of trans people have typically been conducted in medical environments such as gender clinics and through sexual health centres (e.g. Clements-Nolle et al., 2001; De Cuypere et al., 2005). The number of studies that have used community samples of trans people is relatively small. In part, this may be because of the difficulties associated with recruiting from a small, highly dispersed and somewhat marginalized population. Regardless of setting, studies that have been conducted with trans people have often suffered from small sample sizes and existing research has focused on a small number of topics, including outcomes of sex reassignment surgery (SRS) (Barrett, 1998; De Cuypere et al., 2005; Lawrence, 2005; Rehman et al., 1999; Smith et al., 2005), estimates of mental illness (Haraldsen and Dahl, 2000; Hepp et al., 2005), and HIV prevalence and risk behaviours (Clements-Nolle et al., 2001; Edwards et al., 2007).

In line with a focus on estimating rates of mental illness in this population, early studies typically viewed people who were then described as transsexuals as suffering from serious mental health problems and gender dysphoria was sometimes taken as an indication of underlying psychopathology (Haraldsen and Dahl, 2000). Many of these studies, however, were flawed methodologically, with a lack of consistent measurement, poor sampling and limited use of control or comparison groups (Midence and Hargreaves, 1997). More recently, an increasing number of studies have not supported the claim that transsexualism is associated with psychopathology. Rather it has been found that trans people, or people diagnosed with Gender Identity Disorder, experience low levels of psychopathology (e.g. depression, anxiety, personality disorders), with rates that are similar or somewhat higher than found in the general population (Cole et al., 1997; Haraldsen and Dahl, 2000; Hepp et al., 2005). Furthermore, transsexuals report improved mood and general functioning once there is recognition of the condition and a process of treatment (e.g. therapy, hormones or surgery) initiated (Cole et al., 1997).

Of the few studies that have examined the prevalence of depression in trans or transsexual populations most have found a slightly higher rate of depression than in the comparable general population. Hepp (2005) reported that 13 percent of 31 respondents diagnosed with Gender Identity Disorder who were receiving treatment for sex reassignment were currently depressed, while Haraldsen and Dahl (2000) reported 17 percent of 86 transsexuals who had applied for or received SRS were currently depressed.

There are many reasons why a trans person may experience depression or depressive symptoms. Depression and distress may arise as a result of experiencing gender dysphoria; it can be associated with the process of gender reassignment (including attempts to gain access to such treatments); it may develop in response to gender-related treatments (e.g. adverse reactions to hormones or through unsatisfactory outcomes), or because of discrimination and abuse relat-

Downloaded from fap.sagepub.com by guest on April 11, 2016

ing to gender identity (Clements-Nolle et al., 2006). Alternatively, depression may be unrelated to an individual's gender identity; depression formed one element of interest in this study and was of interest particularly in relation to health service use and especially for mental health issues.

In sum, many aspects of the trans experience have not been adequately described, and the current body of research under-represents trans people who do not wish to transition (or those who cannot), those who are not mentally ill and those who are HIV negative or not at risk of contracting HIV. Further, there is only a limited amount of research conducted with Australian and New Zealand trans people.

METHODS

The decision was taken to conduct an online survey. Recently, a number of studies have successfully used the internet and online surveys to recruit non-medical samples of trans individuals (e.g. Lombardi et al., 2001; Mathy, 2001; Newfield et al., 2006). The most recent of these studies investigated the feasibility of using internet research to capture what was described as 'a hidden sexual minority' (Rosser et al., 2007). The researchers indicated that many of 'these sexual minority populations appear to be early adopters of the internet, with virtual communities providing social and sometimes sexual support' (Rosser et al., 2007: 51). The internet also allows access to the survey from all parts of the country. Unlike most studies of trans people that have predominantly recruited from inner cities, this methodology allowed access from all parts of Australia and New Zealand. The internet provides safe spaces for non-heterosexual individuals and communities, and so can be used to reach fragmented populations spread across large distances (Harding and Peel, 2007). The anonymity of an online survey provides an opportunity for respondents to protect their identity, and reduces fear of discovery or being 'outed' in terms of their non-conforming gender identity or feelings. Online surveys have also proven to be effective in recruiting other marginalized populations such as gay, lesbian and bisexual people in Australia, New Zealand and overseas (Henrickson et al., in press; Hillier et al., 2005; Pitts et al., 2006; Riggle et al., 2005).

The survey was designed in consultation with members of a number of trans communities. Submissions offered by trans men and women on their experience with the Private Lives survey (Pitts et al., 2006) were used to begin the development of the survey. Through consultation it became clear that questions of access to health services were considered important to the trans population. Consultation also contributed to the development of questions, and their appropriate wording. A number of trans people from around Australia also provided useful questions and suggestions via email. Although there was variation in advice received (and some contention) on preferred nomenclature for identities and terms for medical procedures (e.g. 'gender affirmation surgery' was preferred to either sex re-

Downloaded from fap.sagepub.com by guest on April 11, 2016

assignment surgery or gender re-assignment surgery) several views did prevail. One was that 'transgender' was the most commonly used general term, and any term that implied a simple binary was unacceptable. For example, on the basis of consultation advice, the terms MTF (male-to-female) and FTM (female-to-male), conventional in the literature, were avoided in the survey questions, and are only used in the report of the whole study (Couch et al., 2007) when quoted from a participant. Once the survey was online, the trans communities and individuals who had participated in the initial consultations became instrumental in encouraging others to participate.

To capture the variation of identity and experience present in this population, a combination of quantitative and qualitative questions was used in the survey. Respondents were given opportunity, throughout the survey, to give an account of their lives and experiences with health services in their own way, and in their own words and expression.

Emails publicizing the survey were sent out to trans support organizations in Australia and New Zealand. AIDS councils, which have regular contact with the trans communities in both countries, were also contacted. Email invitations were also sent out to key community members who have close contact with, or are a part of, the trans communities. The launching of the survey was reported in the Australian GLBTI community press and on radio in Melbourne. Efforts were also made to recruit trans people from indigenous communities through respective AIDS councils and the Outblack organization. The invitations asked people who identified as trans to 'be part of Australia's largest online survey of the health and well-being of trans people'. Business cards that had a brief description of the survey and the URL were distributed to various locations across Australia and at General Practitioner clinics with high case-loads of trans patients. Ethics approval for the survey was granted by the La Trobe University Human Research Ethics Committee (Reference No. 06–90).

Quantitative data were analysed using SPSS® Version 14 (manufacturer: SPSS Inc.), descriptive statistics were computed and comparative statistical analyses such as chi-square analyses and *t*-tests were performed to detect differences between different groups of respondents. All statistical differences are reported at $p < .05$. The analysis of the qualitative data was managed using the software package NVivo, version 7 (manufacturer: QSR International). Open and axial coding was used to identify themes and their interconnection.

FINDINGS

The survey was available online from October 2006 to January 2007. In all, 287 people responded to the survey. Of these, 27 resided in a country other than Australia or New Zealand and seven had substantial missing data. In total, 253 respondents completed the survey and were considered eligible on the basis that, since we asked specifically about health service use, we excluded those who

Downloaded from fap.sagepub.com by guest on April 11, 2016

TABLE 1
Demographic characteristics of the sample

Demographic variable	N	%
Country of birth		
Australia	169	68.1
New Zealand	28	11.3
England	31	12.5
Other	20	8.1
Indigenous status		
Aboriginal or Torres Strait Islander	4	1.6
Maori	4	1.6
Place of residence (Australia)		
Major city	94	67.3
Inner regional area	28	20.1
Outer regional area	12	8.6
Remote area	5	3.6
Place of residence (New Zealand)		
North Island	17	70.8
South Island	7	29.1
Highest Level of Education		
Primary school	2	0.8
Secondary school	82	32.4
Diploma/trade certificate	80	31.6
University degree	54	21.3
Postgraduate degree	35	13.8
Employment status		
Full time	104	41.4
Part time	32	12.6
Student	25	9.9
On Benefits	41	16.2
Unemployed	23	9.1
Retired	17	6.7
Sex on original birth certificate		
Male	191	75.5
Female	62	24.5

were not living in the two countries of interest (Australia and New Zealand). Of the 253 respondents, 229 were from Australia (90.5%) and 24 (9.5%) were from New Zealand. They included people from all states and territories in Australia and from both islands of New Zealand. Table 1 gives further demographic information about the sample.

Of the 60.4 percent of Australian respondents who provided postal codes, the majority (67.3%) were living in a major city. This is very similar to 2001 census data, where 66 percent of the Australian population was living in major cities, 21 percent in inner regional areas, 11 percent in outer regional and 3 percent in

Downloaded from fap.sagepub.com by guest on April 11, 2016

remote areas. Consistent with New Zealand census data (Statistics New Zealand (SNZ), 2006), the majority (58.8%) of New Zealand respondents were living in the North Island. Auckland (33.3%) was the city most commonly listed as site of residence.

Respondents reported the sex recorded on their original birth certificate. Of the sample, 75.5 percent (191) reported male and 24.5 percent (62) female. This ratio of 3:1 assigned males to assigned females is roughly equivalent to the sex ratios reported in prevalence studies of Gender Identity Disorder (GID) and transsexualism that have been conducted in European countries (De Cuypere et al., 2007; Garrels et al., 2000; van Kesteren et al., 1996; Weitze and Osburg, 1996; Wilson et al., 1999).

Respondents whose sex was assigned male at birth were on average older than those who were assigned female (44.6 years and 30.6 years respectively; t (125.2) = 8.55, $p < .0005$). Proportionally more assigned females were aged less than < 30 years, fewer were aged between 30–59 years and none were aged over 60 years ($\chi^2(2) = 46.02$, $p < .0005$). It is unclear as to why there is an age difference between these two groups. One possible explanation is that age difference reflects that female-to-male transsexuals typically present for treatment of gender dysphoria or trans feelings at a younger age than male-to-female transsexuals (Garrels et al., 2000; Olsson and Moller, 2003). It is rare for female-to-male transsexuals to seek treatment for the first time during middle age, but not uncommon for male-to-female transsexuals (van Kesteren et al., 1996). Respondents in this study who had been assigned male at birth reported transitioning late in life:

> I was born a male with female gender identity, I have lived a Christian life as a male for 53 years and provided for my family. I am now a 56 year old single female who has made a new life without the ones who matter most to me, simply because they cannot come to terms with what I have had to do to survive. (Participant 114)

A view frequently expressed by assigned males who had transitioned late in life was that they wished that they had started the process earlier: one participant wished she had 'done something … years ago, like 40 years' (Participant 195) and another, who would have come out at age 16 but for the fear of being 'kicked out of home', found herself at age 30 'just [wanting] it all done' (Participant 283). Further analyses revealed no differences between assigned females and males in education, income, location of residence (metropolitan or rural) or country of residence between those assigned male at birth and those assigned female. It is important to note that, in general, very few differences were found between those assigned male and those assigned female at birth, and unless noted directly, the reader should assume there were no differences between these two groups.

General Health and Well-being

Respondents rated their health on a five-point scale from 'poor' to 'excellent'. The majority of the sample rated their health as 'good' or 'very good' (35.2%

Downloaded from fap.sagepub.com by guest on April 11, 2016

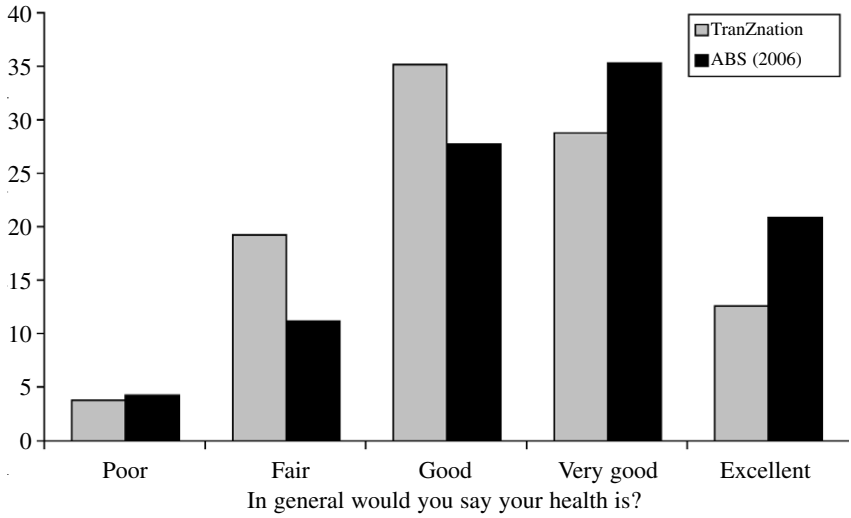

FIGURE 1
Self-rated health

and 28.9% respectively; see Figure 1). These ratings of general health were comparably lower than those reported in the Australian National Health Survey (Australian Bureau of Statistics (ABS), 2006).

Respondents rated their current health compared with their health one year ago on a five-point scale. The majority of the sample (51.2%) rated their health as 'about the same', just over a third rated it as 'somewhat better' (24.2%) or 'much better' (11.9%), while a minority rated it as 'somewhat worse' (12.3%) or 'much worse' (0.4%). More New Zealand respondents rated their health as 'much better' than one year ago, while more Australia respondents rated themselves as 'somewhat better' ($\chi^2(4) = 9.89$, $p = .042$).

The general health subscale of the SF-36 is a five-item scale that assesses perception of general health function (Ware and Gandek, 1998). The SF-36 has been used as a measure of health in a large number of studies worldwide (Hemmingway et al., 1997; Ware et al., 1998) and has been demonstrated to have good reliability and validity in Australian (Butterworth and Crosier, 2004; Sanson-Fisher and Perkins, 1998) and New Zealand (SNZ, 1999) populations. Each item is rated on a 1–5 scale, with the items weighted and summed so that the measure has a range of 0–100. A greater score indicates better health. The mean score for this sample was 65.06 (SD 20.82) (median 67.00, mode 72.00), which is lower than the mean average reported in population norms for Australia (71.6, ABS, 1995) and New Zealand (73.8; SNZ, 1999). A difference of five points is suggested to be of clinical or social significance (Ware et al., 1994). These results indicate that the health of trans people is poorer than the general population in Australia and New Zealand.

Downloaded from fap.sagepub.com by guest on April 11, 2016

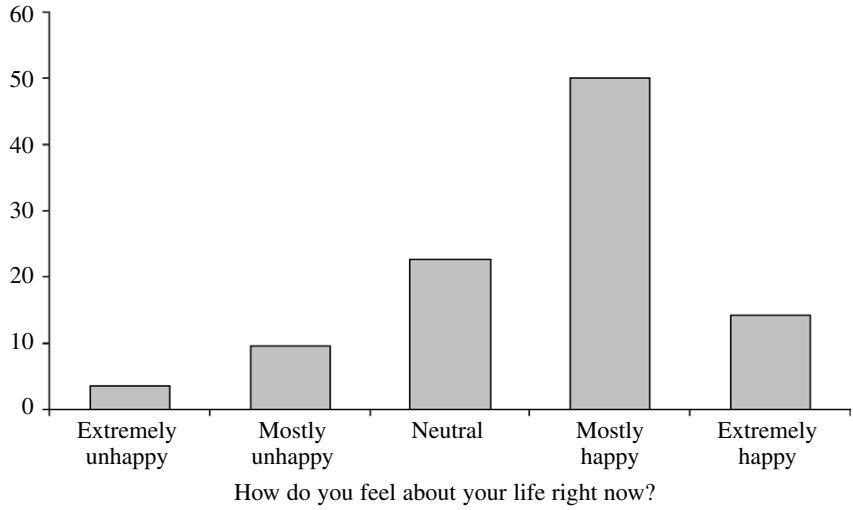

FIGURE 2
Ratings of well-being

A majority of respondents reported that they were happy about their life, with almost two-thirds (65%) reporting that they felt mostly or extremely happy (see Figure 2). As with Cole et al.'s (1997) research cited above, respondents frequently reported an increase in well-being after transitioning, and often expressed this emphatically when given the opportunity to do so: 'It's amazing to have found me after 48 yrs and now that I have, I'm out to have fun' (Participant 253).

Transitioning often involved hormone treatment – 73.1 percent of respondents had accessed hormone treatment – and sometimes surgery (39.1%). One respondent, commenting on her experience of hormone therapy, wrote:

> For the first year my Depression disappeared and as my body changed so to did my personality opening up more and being more socially accepted by my peers. Now, under three quarters of the way through my 'second puberty' Life has its ups and downs, but generally I live a happy and content life, if not the perfect one. (Participant 90)

Depression

Depression was assessed in *TranZnation* by the Prime-MD, a nine-item scale that has been used to measure depression in the Australian general population (Goldney et al., 2000) and in Australian GLBTI samples (Pitts et al., 2006; Rogers et al., 2003). Respondents indicated whether they had experienced symptoms of depression in the past two weeks. Two items were screening questions: one asks about feeling down, depressed or hopeless and the other asks about anhedonia (little interest or pleasure in doing things).

Downloaded from fap.sagepub.com by guest on April 11, 2016

TABLE 2
Depression

In the past two weeks have you experienced any of the following?	Total sample N	Total sample %
Feeling down, depressed or hopeless	123	49.0
Little interest or pleasure in doing things	88	35.3
Trouble falling asleep or sleeping too much	132	52.6
Feeling tired or having little energy	168	66.9
Poor appetite or over eating	104	41.6
Feeling bad about yourself	114	45.6
Trouble concentrating	76	30.2
Change in activity levels	59	23.7
Better off dead or thought of hurting yourself	63	25.0

Overall, 53.4 percent of respondents answered in the affirmative to at least one of the two screening questions and just over one third (36.2%) met the criteria for a current major depressive episode (see Table 2). This rate of depression is higher than that found in our earlier GLBTI survey, Private Lives (which used the same measure of depression) where a quarter (24.4%) of the sample was currently depressed. Furthermore, it is much higher than the level of depression found in the general Australian population. Using the Prime-MD, Goldney et al. (2000), for example, reported 6.8 percent of respondents in a large representative community sample were clinically depressed. As one respondent, reflecting on their situation, wrote about their depression:

> As for depression and feeling down or stressed, who wouldn't with my history? ... I am absolutely sure I made the right decision to transition. My future as female would have been very bleak and I could only see myself surviv(ing) under a heavy dose of anti-depressants for the rest of my life. (Participant 79)

Of some concern is the finding that one in four respondents (25.0%) reported suicidal thoughts in the two weeks before they completed the survey. This level of suicidal ideation was also higher than in Private Lives (15.7%) (Pitts et al., 2006). Other studies of trans populations have also reported high rates of suicidality. Mathy (2001) found in a community sample of 73 trans respondents that 37 percent reported having had suicidal ideation at some point in their lives. Similarly, Clements-Nolle et al. (2006) reported that 32 percent of 515 trans respondents had attempted suicide. The dual findings that the majority of our respondents reported feeling happy overall with their lives and the high level of reported suicidal thoughts exemplify the complexity of experience and emotions for this group.

When analyses were conducted that grouped respondents according to their sex at birth, it was found that almost twice as many assigned males were suffering from a depressive episode at the time of the survey than assigned females (40.9% and 21.3% respectively) ($\chi^2(1) = 7.24$, $p = .007$). Furthermore, roughly double the proportion of those assigned male at birth reported suicidal ideation in the

Downloaded from fap.sagepub.com by guest on April 11, 2016

past two weeks than those assigned female (28.3% and 14.8%, $\chi^2(1) = 4.51$, $p = .034$). It is unclear why there is a higher rate of depression amongst assigned males in the sample. Further analysis indicated that the difference was not a result of the difference in ages between the two groups of respondents. Finally, there was a clear relationship between increasing age and lower rates of depression in those assigned male at birth ($\chi^2(2) = 9.65$, $p = .008$). No relationship between age and depression was found for respondents with female on their original birth certificate.

Experience of depression in the past was assessed two ways: respondents were asked if they had experienced a time when they were more depressed or down or had less interest in things, and whether they had been diagnosed with depression in the past. Of the respondents, 82.1 percent said that they had had a time when they were more depressed/down, or had less interest in things. There were significantly more respondents from Australia reporting a period when they had been depressed than New Zealanders (84.2% and 65.2% respectively) ($\chi^2(1) = 5.21$, $p = .022$). For respondents who indicated that they had had a time when they were more depressed, they were also asked whether they experienced any of the symptoms of depression mentioned above, such as trouble sleeping, concentrating, feeling tired, poor appetite, little interest in doing things. Of the respondents who had indicated that they had had a time when they were more depressed, 96.6 percent indicated that they had suffered one or more of the symptoms of depression measured by the Prime-MD.

Almost half of all respondents (49.4%) reported that they had been diagnosed with depression in the past. Of those that had, the mean age when first diagnosed was 32.0 years and the mean number of years between being first diagnosed with depression and the time of survey was 10.6 years. Not surprisingly, there was a clear relationship between experiencing discrimination, stigma and depression. One participant who had a difficult time coming out reported:

> My gender status caused me to lose my full time employment and depressive feelings often make me less motivated to make the most of my life. Coming out to people has resulted in a good deal of rejection from both friends and neighbours alike. (Participant 282)

Respondents who had experienced a greater number of different types of discrimination were more likely to report being currently depressed (as measured by the Prime-MD; see Figure 3). For example, 10 percent of those who had not experienced any of the listed types of discrimination were depressed, while just over 60 percent of those who had experienced 10–12 types of discrimination were currently depressed. Overall there was a significant relationship between number of types of discrimination and reported depression ($\chi^2(45) = 87.7$, $p = .0001$).

A major depressive episode, sometimes including a suicide attempt, could be the catalyst for transition. For respondents, this often came after a long period of ignoring their feelings about their gender and trying to live as their assigned sex. This could have an alleviating or compounding effect:

Downloaded from fap.sagepub.com by guest on April 11, 2016

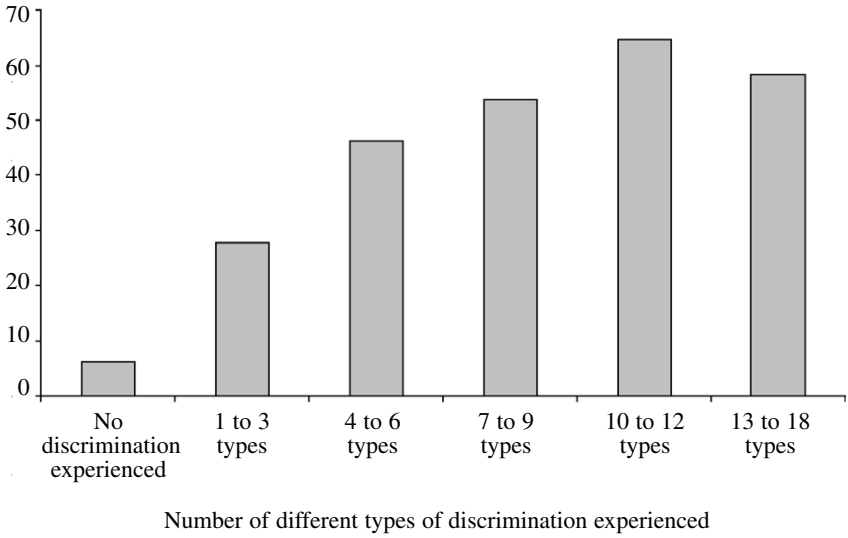

FIGURE 3
Relationship between depression and experience of stigma and discrimination

> Due to the fear of public humiliation and ridicule and the fear of rejection by family and friends, I have kept this hidden all my life. Recently due to increasing inner pressure and depression, I have come out to my family and close friends who fortunately have been very supportive. (Participant 111)

> As a male I overachieved and met success even though I was aware of my gender problem and did my best to hide it. Depression just became worse and lead to a general collapse and suicide attempt in 2003. When I finally acknowledged GID and came out the following happened: (a) divorce (b) loss of friends (c) loss of employment. I wish I could say the truth sets you free. (Participant 43)

Health Service Use and Experiences

Respondents had used a wide range of health services in the previous 12 months, with a small proportion accessing services that are related directly to being trans, e.g. speech pathology, gender presentation services (see Table 3). Relating to health services can be a difficult experience for people who are trans, as their gender identity is often revealed or scrutinized. General practitioners play an important role in providing and coordinating medical care (general and specialist), as well as ongoing support and counselling for trans people (Meese, 1997). Four out of every five respondents reported that they had a regular doctor (82.1%). Respondents were more likely to have a regular doctor if they were older ($\chi^2(2) = 8.44$, $p = .015$). Of the respondents reporting a regular doctor, 83.4 percent had had a check up in the last 12 months.

Downloaded from fap.sagepub.com by guest on April 11, 2016

TABLE 3
Health service use in the past year

Health service	Total N	Total %
Counsellor/psychologist/psychiatrist	120	47.4
Dentist	109	43.1
Hospital – inpatient	52	20.6
Hospital – outpatient	47	18.6
Hospital – accident/emergency unit	40	15.8
Sexual health clinic	40	15.8
Physiotherapist	34	13.4
Chiropractor/osteopath	32	12.6
Speech pathologist	19	7.5
Trad. Chinese practitioner, etc	16	6.3
Naturopath	14	5.5
Gender presentation services	12	4.7
Kinesiology	7	2.8
Other	38	15.0

Note: Multiple responses possible

Hospitals had been accessed by 15–20 percent of respondents in the past year and a minority had used a number of other specialist services to varying degrees. The most commonly accessed was a mental health professional, used by almost half the sample (47.4%). An equivalent rate of use of psychotherapy by trans people was found by Mathy (2001) who reported that, in a sample of 73 trans people living in North America, 53.4 percent had used a psychotherapist. This level of use is not surprising given the prevalence of depression in the sample, and that counselling/psychotherapy is typically required before an individual undergoes sex reassignment surgery. Proportionally more respondents who were assigned female at birth had accessed a counsellor, psychologist or psychiatrist than those assigned male at birth (61.3% and 42.9% respectively; $\chi^2(2) = 6.33$, $p = .012$). It was also found that 18 of the 19 respondents who had been assigned male at birth had used a speech pathologist. Speech pathology is used by trans people to gain a sex appropriate voice, e.g. to 'masculinize' or 'feminize' the voice, and this is an important part of being accepted in a new gender (McNeill, 2006). Assigned females generally achieve masculinization of the voice through hormone treatments. Similar treatments for assigned males, however, have less impact on voice pitch; assigned males thus often access speech pathologists to 'feminize' their voices. Additionally, it may also be more difficult for a trans woman to 'pass' with a deep voice than for a trans man to 'pass' with a high voice. As one participant assigned male at birth wrote: '[My] voice is my biggest obstacle to "passing"' (Participant 252).

When respondents were asked what other health services they used, the most

Downloaded from fap.sagepub.com by guest on April 11, 2016

common answer was endocrinologist (listed by 12 respondents), i.e. a specialist doctor involved in hormone treatments. Given that accessing an endocrinologist was not directly asked about, and that hormone treatments are widely used by trans people, this is likely to be an underestimate of the number who had seen an endocrinologist in the past year.

Half (50.7%) of the Australian respondents had private health insurance, a level identical to the rate for the general Australian population reported in the Australian National Health Survey (ABS, 2006). In comparison, few New Zealand respondents had insurance (13.0%). Both countries have complicated combinations of state and private insurance funding for health services. It is generally the case that individuals with private health insurance can expect easier access and choice of health practitioners and services. In general, cost of private health insurance seemed to be a limiting factor in achieving access to desired health services. Sixty-six percent of all respondents who did not have insurance said they would like to have it but could not afford it. Accordingly, respondents with a higher income were more likely to have private health insurance than those with lower (below $40,000) incomes ($\chi^2(3) = 20.78$, $p < .0005$). As one participant without insurance commented, 'paying insurance is me betting that I'll be sicker than average and claim more than I paid. This is not a bet I want to win, so I won't make it, thanks' (Participant 211).

Respondents described their best and worst experiences with a health practitioner or health service in relation to being trans (these were open-ended questions in the survey). For many respondents, the best experiences in the health system involved encounters where they felt accepted and supported by their practitioners. When conducted appropriately, interaction with the medical community was a profoundly legitimating and positive experience.

> [My best experience with a health service was] when my views on my gender are accepted as authoritative. (Participant 211)

> [My best experience with a health service was] the first time I was able to tell a doctor and have him accept what I said. (Participant 176)

> My current medical team including my GP, Psychiatrist and Endocrinologist are a wonderful caring and professional group who include me as an equal partner in my transition. (Participant 166)

As would be expected, respondents valued practitioners who showed empathy, and were understanding, compassionate and professional.

> Nearly all health practitioners I have come into contact with since starting to deal with gender issues have been extremely warm and professional, perhaps because I have kept this in mind when choosing who I consult. My GP who is my main healthcare provider had had no prior experience with transgendered patients, but was very open-minded and eager to learn more along the process. (Participant 116)

Downloaded from fap.sagepub.com by guest on April 11, 2016

Professionalism was often linked to a non-judgmental attitude, and to a respect for patients' gender identities. This respect was conveyed through the appropriate use of pronouns, use of patients' chosen names and making an effort to change medical records to fit with gender identities. Respondents experienced these as 'positive affirmations' of their gender (Participant 129), and it allowed them to feel like 'everyday, "normal" (people)' (Participant 262) in the often difficult process of consulting health services about trans health issues.

It was common in their accounts for respondents to report being met with a degree of curiosity and surprise in their encounters with health services. This could range from 'just the odd raised eyebrow, nothing serious' (Participant 18), to feeling like 'a bit of a novelty or freak show' (Participant 262). Some respondents preferred it when practitioners seemed to be 'oblivious' (Participant 25) to their trans status, or when they 'didn't even bat an eyelid' (Participant 04) upon learning about it.

Respondents' worst experiences with health services usually involved encounters where they were met with hostility. These ranged from instances where respondents sensed discomfort, contempt and resentment, to occasions of being refused treatment, laughed at, ridiculed, and met with outright displays of disgust. Examples included 'being told that (one was) the filthiest most perverted thing on earth' (Participant 11), or that one 'needed to find god not hormones' (Participant 132). For some, prejudice and contempt came to be expected. Sometimes respondents were grateful simply for the absence of explicit displays of these: 'Most males in the health service try not to show their distaste for my condition, and I appreciate that' (Participant 73).

Attending sex-specific medical clinics that were discordant with respondents' gender identities could be a difficult experience. Some people avoided using these services altogether. The experience could be made even more difficult by medical staff who did not respect respondents' gender identities. For one participant, the negative experience with a health service that stood out was 'having a hysterectomy, being [in] a gynaecological ward … and [the] staff she'ing [him]' (Participant 81). Medical staff could also disaffirm a person's gender identity by using the wrong name, and could sometimes be flippant about confidentiality, for example 'calling out the wrong (former) name in a waiting room full of people' (Participant 24).

A few respondents said that they had never spoken to health professionals about trans health issues and others said that they were often reluctant to disclose their trans status with practitioners when being treated for health problems. Fear of being 'stereotyped and boxed' (Participant 105), pathologized, labelled, judged, stigmatized, met with hostility and ignorance, were some of the reasons that people gave. These fears were sometimes based on the experiences of other people, or on an individual's past experiences with health services. One woman explained her reluctance to use a health service in terms of, 'Fear of the health system. After bad experiences I'm scared to use it because I know it's not really there for me' (Participant 289).

Downloaded from fap.sagepub.com by guest on April 11, 2016

Discomfort about having to expose one's genitalia was a common theme in the data, both in respondents' accounts of their reluctance to use health services, and in descriptions of respondents' best and worst experiences with health services. Practitioners who were sensitive to the difficulties that trans people face in healthcare settings, and who recognized respondents' unease over medical check-ups, were valued greatly. One participant who felt self-conscious about baring parts of himself said that he felt at ease with his plastic surgeon who he found to be 'professional and respectful' (Participant 24). Another said this of his general practitioner:

> She realizes I have big issues relating to female health issues. Pap Smear, breast check – Eeeeeew! – she does everything she can to put me at ease. Whilst having yucky pap thing still calls me sir! Love it. (Participant 132)

Practitioners were greatly appreciated if they were knowledgeable and experienced in trans issues, and if they were sensitive to gender diversity and to the difficulties that trans people face in healthcare settings. Of course, knowledge about appropriate hormone treatment and surgery is also important. Many respondents, however, found that their doctor had little experience in treating trans people, and needed to gain new skills in order to take them on as patients. This situation was not necessarily experienced negatively. While some people wished that their doctors had been taught how to treat trans patients in medical school, and did not need to be educated by their patients, others were happy to have open-minded doctors who 'learned with [them]' (Participant 127), and who showed an interest in trans issues.

Respondents pointed to a need for a more complex understanding of gender in the health system. Many cited this as one of the things they would change about the health services that they had accessed. Respondents argued that practitioners needed to be aware of the 'diversity of gender identities' (Participant 21) and to recognize that 'transpeople are a diverse bunch of people with diverse needs' (Participant 22). Respondents also commented on the scarcity of health services for trans people in the public system, commonly reporting long waiting periods for accessing services. This situation kept some respondents from accessing these services altogether.

Some respondents advocated greater peer involvement in trans health services. Respondents felt that 'proper trans community consultation' (Participant 22) might contribute to a more complex, experience-near understanding of trans identities and their relevance for the healthcare of trans people. It would also complete health professionals' gaps in knowledge about suitable hormone treatment and surgery. Based on their experiences with health services, some respondents also felt that they would have been more comfortable consulting trans counsellors and health professionals.

> Trans that have gone before me have a wealth of knowledge as they have tried and failed or succeeded in lots of things. More notice needs to be taken of them. (Participant 253)

Downloaded from fap.sagepub.com by guest on April 11, 2016

DISCUSSION

These results offer a complex picture of the health and well-being of trans people living in Australia and New Zealand. Because of the nature of recruitment and sampling we cannot know how representative this sample is of the general population of trans people. Further, we did not impose any exclusion criteria in order to allow for people to self-identify as within the 'target group' for this survey. Nonetheless, this is likely to be a broader sample than those recruited from clinical settings where the focus is frequently on 'stages' in 'a journey' of transitioning.

Whilst overall levels of health and well-being are not vastly different from estimates from the general population, it is clear that there are major mental health issues for these communities. Depression is a major problem for many trans people and is clearly linked with experiences of stigma and discrimination. Unfortunately some of this discrimination emanates from health professionals; although the empowerment associated with appropriate recognition and respectful service provision is also evident from the responses in this study.

The desire for recognition is pivotal to the concerns of the trans communities about health services. Practices of medicine are implicated in many of the attempts by trans people to achieve positive health and self- and social-recognition for their identified gender. Additionally, recognition on formal documentary records is, in many cases, dependent upon certified medical intervention. Commonly, trans people have an ambivalent relation to medicine: on the one hand resisting the over-medicalization of their lived experience; and on the other, recognizing their need of the interventions of medicine – such as hormone treatment and surgery – in achieving the desired social and inter-personal recognition.

Where, then, do the theories and practices of psychology and feminism intersect with the lived experience of trans people in their attempts to find social and inter-personal recognition in and through their interactions with health practitioners and health services? In introducing their book on lesbian, gay, bisexual, trans and queer psychologies, Clarke and Peel (2007) acknowledge the difficulties in locating trans in relation to gay and lesbian psychology: 'Although some trans women and men identify as lesbian, gay or bisexual, the argument goes that trans oppression is better dealt with under the rubric of gender oppression (which is the domain of feminism)' (2007: 24). At the same time, they acknowledge that this is complicated by the treatment of trans people in some radical forms of feminism:

> Any move to locate trans under the umbrella of gender studies is complicated by the fact that feminism is not always a welcoming space for trans people. Some of the most trenchant critiques of trans comes from feminists, particularly radical feminists (Jeffreys, 2003; Raymond, 1979). This does not of course mean that all feminists are critical of trans. (Clarke and Peel, 2007: 25)

As an example of a feminist who takes an alternative view to that of radical feminism, Clarke and Peel refer to the work of Johnson, who examines

Downloaded from fap.sagepub.com by guest on April 11, 2016

transsexualism in their volume (Johnson, 2007). She points to the destabilizing of some trenchantly held feminist positions, through an examination of the lived experience of trans:

> detailed research into transgender phenomenon that is sensitive to the lived experience of transsexual and transgendered people reveals that the material grounding of their new gender experiences can also unravel the certainty of particular pervasive discourses. … analysis of the narratives of individuals who identify as transsexual or transgendered reveals a considerable variation in the discourses they draw on to conceptualize what it means to be transsexual … and offers challenges to some feminist interpretations and critiques. (Johnson, 2007: 457)

Other recent debates concerning trans activism and the lived trans experience acknowledge moves to both construct and simultaneously deconstruct a trans identity (Bernstein, 2005; Broad, 2008; McNay, 2008).

Our findings make evident the lack of congruence between the variety and complexity of the lived transgender life, its 'recognition' and the systemization required by health services. Our consideration of the findings of this study, including accounts of lived trans experience and the desire for recognition in matters of health, well-being and access to health services was helped by the social theory associated with Axel Honneth, with its integration of recognition with self-confidence, self-respect and self-esteem. Axel Honneth's ethics of recognition (Honneth, 1995), later elaborated in dialogue with Nancy Fraser (Fraser and Honneth, 2003) encompasses both the recognition of rights and cultural appreciation. As Deranty and Renault (2007) argue, Honneth moves from a hermeneutic of experiences of injustice to an ethics of recognition – that is the ethics involved in the social distribution of recognition – 'because the various feelings of injustice point to three main spheres of recognition' (2007: 97): recognition through intimacy by which affective needs are fulfilled, leading to self-confidence; recognition of the equal dignity of persons, granting self-respect; and recognition of the individual's contribution to the social division of labour, which provides self-esteem. To use Honneth's ideas, there are ample accounts in this study of experiences of injustice through the refusal of recognition in some cases, and misrecognition in others. As McNay (2008: 272) describes it: 'for Honneth, social and political conflict have their source in the 'moral' wounds that arise from the myriad ways in which the basic human need for recognition is disregarded in unequal societies.'. This study describes ways in which wounds are experienced, in unjust ways, to self-confidence, self-respect and self-esteem.

Nancy Fraser has produced one of the most sustained critiques of Honneth's approach. For Fraser, recognition is redefined 'not as psychological injury but as "status subordination" understood as institutionalized patterns of discrimination and value inequality' (McNay, 2008: 272). It is beyond the scope of our data to bridge this gap between Honneth's and Fraser's approaches, theoretically or otherwise. What does emerge most clearly from our study is the desire for recognition and access. As Broad describes it, when interviewing a key national

Downloaded from fap.sagepub.com by guest on April 11, 2016

transgender activist about access in regard to medical care, the activist replied: '*That* is a concern, but more so is access to *everyday* life' (2008: 253, italics in original). The activism that led to this study, and the recognition demanded by the respondents can best be characterized by the final comment of one respondent:

> I think it [the TranZnation survey] is a positive step to help the transgender community get some of the issues we face in to the public forum and hopefully some respect from the wider community as a whole in our quest to live a complete life in our respective gender roles.

NOTES

1. Usage of the term 'trans' was a suggestion from the guest editors of this journal who judge that this term (rather than transgender) seems to be increasing in usage as the umbrella term for these communities. In our consultation with communities before and during the study reported here, the most commonly preferred term was 'transgender'.

REFERENCES

ABS (1995) *National Health Survey: SF-36 Population Norms* (4399.0). Canberra: ABS.

ABS (2006) *National Health Survey: Summary of Results* (4364.0). Canberra: ABS.

Barrett, J. (1998) 'Psychological and Social Function Before and After Phalloplasty', *International Journal of Transgenderism* 2(1), accessed 13 July 2009. Available: http://www.symposion.com/ijt/ijtc0301.htm

Bernstein, M. (2005) 'Identity Politics', *Annual Review of Sociology* 31: 47–74 .

Broad, K.L. (2008) 'GLB+T?: Gender/Sexuality Movements and Transgender Collective Identity (De)Constructions', *International Journal of Sexuality and Gender Studies* 7(4): 241–64.

Butterworth, P. and Crosier, T. (2004) 'The Validity of the SF-36 in an Australian National Household Survey: Demonstrating the Applicability of the Household Income and Labour Dynamics in Australia (HILDA) Survey to Examination of Health Inequalities', *BMC Public Health* 4(44), accessed 13 July 2009. Available: http://www.biomedcentral.com/1471-2458/4/44

Clarke, V. and Peel, E. (2007) 'From Lesbian and Gay Psychology to LGBTQ Psychologies: A Journey into the Unknown (or Unknowable)?', in V. Clarke and E. Peel (eds) *Out in Psychology: Lesbian, Gay, Bisexual, Gay, Trans and Queer Perspectives*, pp. 10–35. Chichester: Wiley.

Clements-Nolle, K., Marx, R., Guzman, R. and Katz, M. (2001) 'HIV Prevalence, Risk Behaviors, Health Care Use, and Mental Health Status of Transgender Persons: Implications for Public Health Intervention', *American Journal of Public Health* 91(6): 915–21.

Clements-Nolle, K., Marx, R. and Katz, M. (2006) 'Attempted Suicide among Transgender Persons: The Influence of Gender-based Discrimination and Victimization', *Journal of Homosexuality* 51(3): 53–69.

Cole, C.M., O'Boyle, M., Emory, L.E. and Meyer, W.J. (1997) 'Comorbidity of Gender

Downloaded from fap.sagepub.com by guest on April 11, 2016

Dysphoria and other Major Psychiatric Diagnoses', *Archives of Sexual Behavior* 26(1): 13–26.

Couch, M., Pitts, M., Mulcare, H., Croy, S., Mitchell, A. and Patel, S. (2007) *TranZnation: A Report on the Health and Wellbeing of Transgender People in Australia and New Zealand*. Melbourne: Australian Research Centre in Sex, Health and Society.

De Cuypere, G., T'Sjoen, G., Beerten, R., Selvaggi, G., De Sutter, P., Hoebeke, P., Monstrey, S., Vansteenwegen, A. and Rubens, R. (2005) 'Sexual and Physical Health after Sex Reassignment Surgery', *Archives of Sexual Behavior* 34(6): 679–90.

De Cuypere, G., Van Hemelrijck, M., Michel, A., Carael, B., Heylens, G., Rubens, R., Hoebeke, P. and Monstrey, S. (2007) 'Prevalence and Demography of Transsexualism in Belgium', *European Psychiatry* 22(3): 137–41.

Deranty, J.-P. and Renault, E. (2007) 'Politicizing Honneth's Ethics of Recognition'. *Thesis Eleven* 88: 92–111.

Edwards, J.W., Fisher, D.G. and Reynolds, G.L. (2007) 'Male-to-female Transgender and Transsexual Clients of HIV Service Programs in Los Angeles County, California', *American Journal of Public Health* 97(6): 1030–3.

Fraser, N. and Honneth, A. (2003) *Redistribution or Recognition? A Political-Philosophical Exchange* (trans. J. Golb and C. Wilke) London: Verso.

Garrels, L., Kockott, G., Michael, N., Preuss, W., Renter, K., Schmidt, G., ., Sigusch, V. and Windgassen, K. (2000) 'Sex ratio of transsexuals in Germany: the development over three decades', *Acta Psychiatrica Scandinavica* 102(6): 445–8.

Goldney, R., Fisher, L.J., Wilson, D.H. and Cheok, F. (2000) 'Major Depression and its Associated Morbidity and Quality of Life in a Random, Representative Australian Community Sample', *Australian and New Zealand Journal of Psychiatry* 34: 1022–9.

Haraldsen, I.R. and Dahl, A.A. (2000) 'Symptom Profiles of Gender Dysphoric Patients of Transsexual Type Compared to Patients with Personality Disorders and Healthy Adults', *Acta Psychiatrica Scandinavica* 102: 276–81.

Harding, R. and Peel, E. (2007) 'Surveying Sexualities: Internet Research with Non-heterosexuals', *Feminism & Psychology* 17(2): 277–85.

Hemmingway, H., Stafford, M., Stansfeld, S., Shipley, M. and Marmot, M. (1997) 'Is the SF-36 a Valid Measure of Change in a Population Health? Results from the Whitehall II Study', *British Medical Journal* 315(15): 1273–9.

Henrickson, M., Neville, S., Jordan, C. and Donaghey, S. (2008) 'Lavender Islands: The New Zealand Study', *Journal of Homosexuality* 53(4): 223–48.

Hepp, U., Kraemer, B., Schnyder, U., Miller, N. and Delsignore, A. (2005) 'Psychiatric Comorbidity in Gender Identity Disorder', *Journal of Psychosomatic Research* 58: 259–61.

Hillier, L., Turner, A. and Mitchell, A. (2005) *Writing Themselves in Again: Six Years On, the 2nd National Report on the Sexuality, Health and Well-being of Same Sex Attracted Youth in Australia*. Melbourne: Australian Research Centre in Sex, Health and Society (ARCSHS), La Trobe University.

Honneth, A. (1995) *The Struggle for Recognition: The Moral Grammar of Social Conflicts* (trans. J. Anderson) Cambridge, MA: Polity Press.

Jeffreys, S. (2003) *Unpacking Queer Politics: A Lesbian Feminist Perspective*. Cambridge: Polity Press.

Johnson, K. (2007) 'Transsexualism: Diagnostic Dilemmas, Transgender Politics and the Future of Transgender Care', in V. Clarke and E. Peel (eds) *Out in Psychology: Lesbian, Gay, Bisexual, Gay, Trans and Queer Perspectives*, pp. 444–74. Chichester: Wiley.

Downloaded from fap.sagepub.com by guest on April 11, 2016

Lawrence, A.A. (2005) 'Sexuality before and after Male to Female Sex Reassignment Surgery', *Archives of Sexual Behavior* 34(2): 147–66.

Lombardi, E.L., Wilchins, R.A., Priesing, D. and Malouf, D. (2001) 'Gender Violence: Transgender Experiences with Violence and Discrimination', *Journal of Homosexuality* 42(1): 89–101.

Mathy, R. (2001) 'A Nonclinical Comparison of Transgender Identity and Sexual Orientation: A Framework for Multicultural Competence', *Journal of Psychology and Human Sexuality* 13(1): 31–54.

McNay, L. (2008) 'The Trouble with Recognition: Subjectivity, Suffering, and Agency', *Sociological Theory* 26(3): 271–96.

McNeill, E. J. (2006) 'Management of the Transgender Voice', *Journal of Laryngology & Otology* 120(7): 521–3.

Meese, P. (1997) 'The Role of the General Practitioner in the Care of the Transgender Patient', *Venereology* 10(3): 154–7.

Midence, K. and Hargreaves, I. (1997) 'Psychosocial Adjustment in Male-to-female Transsexuals: An Overview of the Research Evidence', *Journal of Psychology* 131(6): 602–14.

Newfield, E., Hart, S., Dibble, S. and Kohler, L. (2006) 'Female-to-male Transgender Quality of Life', *Quality of Life Research* 15(9): 1447–57.

Olsson, S.E. and Moller, A.R. (2003) 'On the Incidence and Sex Ratio of Transsexualism in Sweden, 1972–2002', *Archives of Sexual Behavior* 32(4): 381–6.

Pitts, M., Smith, A., Mitchell, A. and Patel, S. (2006) *Private Lives: A Report on the Health and Wellbeing of GLBTI Australians*. Melbourne: Gay and Lesbian Health Victoria and The Australian Research Centre in Sex Health and Society, La Trobe University.

Raymond, J. (1979) *The Transsexual Empire: The Making of the She-male*. Boston, MA: Beacon Press.

Rehman, J., Lazer, S., Benet, A.E., Schaefer, L.C. and Melman, A. (1999) 'The Reported Sex and Surgery Satisfactions of 28 Postoperative Male-to-female Transsexual Patients', *Archives of Sexual Behavior* 28(1): 71–89.

Riggle, E.D., Rostosky, S.S. and Reedy, C.S. (2005) 'Online Surveys for BGLT Research: Issues and Techniques', *Journal of Homosexuality* 49(2): 1–21.

Rogers, G., Curry, M., Oddy, J., Pratt, N., Beilby, J. and Wilkinson, D. (2003) 'Depressive Disorders and Unprotected Casual Anal Sex among Australian Homosexually Active Men in Primary Care', *HIV Medicine* 4: 271–5.

Rosser, B.R.S., Oakes, J.M., Bockting, W.O. and Miner, M. (2007) 'Capturing the Social Demographics of Hidden Sexual Minorities: An Internet Study of the Transgender Population in the United States', *Sexuality Research and Social Policy* 4(2): 50–64.

Sanson-Fisher, R.W. and Perkins, J.J. (1998) 'Adaption and Validation of the SF-36 Health Survey for Use in Australia', *Journal of Clinical Epidemiology* 51(11): 961–7.

Smith, Y.L.S., Van Goozen, S.H.M., Kuiper, A.J. and Cohen-Kettenis, P.T. (2005) 'Sex Reassignment: Outcomes and Predictors of Treatment for Adolescent and Adult Transsexuals', *Psychological Medicine* 35(1): 89–99.

SNZ (1999) *Taking the Pulse: The 1996/97 New Zealand Health Survey*. Wellington: SNZ.

SNZ (2006) *QuickStats National Highlights: Statistics New Zealand*. Wellington: SNZ.

van Kesteren, P.J., Gooren, L.J. and Megens, J.A. (1996) 'An Epidemiological and Demographic Study of Transsexuals in The Netherlands', *Archives of Sexual Behavior* 25(6): 589–600.

Downloaded from fap.sagepub.com by guest on April 11, 2016

Ware, J.E. and Gandek, B. (1998) 'Overview of the SF-36 Health Survey and the International Quality of Life Assessment (IQOLA) Project', *Journal of Clinical Epidemiology* 51(11): 903–12.

Ware, J.E., Kosinski, M. and Keller, S.D. (1994) *SF-36 Physical and Mental Health Summary Scales: A User's Manual*. Boston, MA.: Health Assessment Lab.

Ware, J. E., Kosinski, M., Gandek, B., Aaronson, N. K., Apolone, G., Bech, P., Brazier, J., Bullinger, M. , Kaasa, S. , Leplège, A., Prieto, L. and Sullivan, M. (1998) 'The Factor Structure of the SF-36 Health Survey in 10 Countries: Results from the IQOLA Project', *Journal of Clinical Epidemiology* 51(11): 1159–65.

Weitze, C. and Osburg, S. (1996) 'Transsexualism in Germany: Empirical Data on Epidemiology and Application of the German Transsexuals' Act during its First Ten Years', *Archives of Sexual Behavior* 25(4): 409–25.

Wilson, P., Sharp, C. and Carr, S. (1999) 'The Prevalence of Gender Dysphoria in Scotland: A Primary Care Study', *British Journal of General Practice* 49(449): 991–2.

Marian PITTS is Professor and Director of the Australian Research Centre in Sex, Health and Society (ARCSHS), La Trobe University. Professor Pitts's research covers health psychology and public health, with focus on health and gender; sex and sexuality.
ADDRESS: Australian Research Centre in Sex, Health & Society, La Trobe University, 215 Franklin Street, Melbourne Victoria 3000, Australia.
[email: m.pitts@latrobe.edu.au]

Murray COUCH is a Senior Research Fellow at the Australian Research Centre in Sex, Health & Society, La Trobe University.
ADDRESS: Australian Research Centre in Sex, Health & Society, La Trobe University, 215 Franklin Street, Melbourne Victoria 3000, Australia.
[email: m.couch@latrobe.edu.au]

Hunter MULCARE was a research assistant at the Australian Research Centre in Sex, Health & Society, La Trobe University, until December 2007.
ADDRESS: Turning Point, 54–62 Gertrude Street, Fitzroy Victoria 3065, Australia.
[email: HunterM@turningpoint.org.au]

Samantha CROY is a research officer at the Australian Research Centre in Sex, Health & Society, La Trobe University.
ADDRESS: Australian Research Centre in Sex, Health & Society, La Trobe University, 215 Franklin Street, Melbourne Victoria 3000, Australia.
[email: s.croy@latrobe.edu.au]

Anne MITCHELL is Associate Professor and the Manager of the Community Liaison and Education Unit at the Australian Research Centre in Sex, Health and Society, La Trobe University, and the director of Gay and Lesbian Health Victoria.
ADDRESS: Australian Research Centre in Sex, Health & Society, La Trobe University, 215 Franklin Street, Melbourne Victoria 3000, Australia.
[email: a.mitchell@latrobe.edu.au]

Downloaded from fap.sagepub.com by guest on April 11, 2016